BONE DENSITY QUESTIONNAIRE

NAME:_____ DATE:_____

PHYSICIAN:_____ DOB:_____

1. Is there a chance you are pregnant? _____
2. Have you had a barium x-ray or nuclear medicine scan or injection of x-ray dye in the last 2 weeks? _____
3. Do you have metal in your spine or hips? _____
4. Have you ever broken (fractured) a bone as an adult? _____
5. Explain any fractures as an adult: (age it happened & how it occurred) _____
6. Have you ever been diagnosed with HYPERPARATHYROIDISM? _____

Do you take calcium pills (including TUMS) daily? _____
Do you take vitamin D daily? _____
Do you take multi-vitamin daily? _____
Do you take hormones now? _____ list type _____
Do you take testosterone now? _____
Do you take Tamoxifen now? _____
Do you take Evista now? _____

Do you take any of these medicines now or have you in the past, please circle:

Etidronate (Didronel/Didrocal)	Alendronate (Fosamax)	Risedronate (Actonel)
Intraveneous Pamidronate (Aredia)	Clodronate (Bonefos, Ostac)	PTH (Forteo)
Calcitonin (Miacalcin nasal spray)	Zoledronic Acid (Zometa) (Reclast)	Ibandronate (Boniva)

List # of daily servings of calcium enriched foods/drinks per day (examples: dairy products, cheese, fortified orange juice, almonds, some leafy greens, ect.) _____

Has your: (MOTHER) (GRANDMOTHER) (SISTER) been diagnosed with a ----
(Hip Fracture) or (Osteoporosis) ---- Please circle

Do you currently receive or have you previously received any of the following: (if yes list how long)

1. medication for seizures or epilepsy _____
2. chemotherapy for cancer _____
3. medication for prostate cancer _____
4. medication to prevent organ transplant rejection _____
5. steroids for chronic asthma or arthritis _____
6. medication for thyroid problems _____

Do you have intestinal problems such as Crohn's Disease or Ulcerative Colitis? _____
Have you had renal kidney failure? _____ if yes, are you on dialysis? _____

Do you currently consume 3 or more alcoholic beverages per day? _____

Do you currently smoke _____ or have you smoked in the past _____?

Last menstrual cycle _____ or age/date of hysterectomy _____
Complete or Partial (circle)

Last Bone Density: (date & place) _____

HEIGHT:_____ WEIGHT:_____ TECH:_____

SIGNATURE	
I ATTEST THAT THE INFORMATION I HAVE PROVIDED ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.	INFECTION CONTROL? Y/N _____
_____ _____	_____
SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO CONSENT FOR PATIENT DATE	TECHNOLOGIST